OUTCOMES:
1. The patient with an existing wound will progress toward healing without infection.
2. Infection in wounds will be cleared and the wound will progress toward healing.

STANDARDS OF PRACTICE:
In the care of all patients with pressure ulcers the nurse will:
1. Assess all wounds and distinguish pressure ulcers from other wounds (venous, arterial, diabetic, surgical) or skin disorders/lesions.
2. Consult Wound and Ostomy Team for any pressure ulcer of Stage II or greater.
3. Perform comprehensive assessment of a pressure ulcer upon identification to include:
   a. Location
   b. Staging according to National Guidelines:
      • **Suspected Deep Tissue Injury:**
        Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
        Per the NPUAP guidelines referenced
      • **Stage I** – Non-blanchable erythema of the skin, redness of area remains 30 minutes after source of pressure removed, epidermis intact. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
      • **Stage II** – Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
      • **Stage III** – Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to,
but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

- **Stage IV** – Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts may also be associated with Stage IV pressure ulcers.

- **Unstageable:**
  
  Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

  c. Measurement of size in centimeters. Unit staff nurse will document initially and every Monday.
  
  d. Exudate or drainage (color, amount, odor).
  
  e. Wound bed characteristics (necrotic, granular, beefy red).
  
  f. Condition of surrounding skin (white, pink, macerated, erythema).
  
  g. Signs of infection (induration, fever, erythema, edema).
  
  h. Tunneling/undermining (ledge).
  
  i. Pain.

4. Initiate appropriate wound care treatment based on wound stage (Table 1 Pressure Wound Treatment). Notify physician of wound within 24 hours of initiating treatment. Obtain additional orders related to dressing changes.

5. Initiate appropriate consults, i.e. Dietitian or Nutritional Support Team, Diabetic Clinical Nurse Specialist. Document.

**References:**

Pressure Ulcer Stages Revised – Updated Staging System 2/2007, copyright, National Pressure Ulcer Advisory Panes. [www.npuap.org](http://www.npuap.org)


<table>
<thead>
<tr>
<th>Stage</th>
<th>Debridement</th>
<th>Cleansing</th>
<th>Dressings</th>
<th>Pressure Relief</th>
</tr>
</thead>
</table>
| I     | NA          | Normal saline and 4 x 4 with each dressing change. | • Keep wound clean, moist and protected.  
• Moisture barrier cream to area as needed, or barrier dressing such as transparent or hydrocolloid. Picture frame around hydrocolloid with Hypafix tape.  
• Reapply barrier cream PRN, or change dressing Q 3 days and prn.  
• Use skin sealant gel on peri-ulcer skin where tape will be applied. | As in Skin Care Standard of Practice (turning wedges, foam heel boots, occipital offloaders, pillows)  
Low air-loss mattress (non-ICU). Total Care in ICU. |
| II    | Consult Wound and Ostomy Team. | Normal saline and 4 x 4 with each dressing change. | • Consult Wound and Ostomy Team  
• Keep wound clean, moist and protected.  
• Hydrocolloid dressing or hydrogel dressing, picture framed with hypafix tape for heels, elbows and coccyx (unless patient incontinent, then apply generous amount of barrier cream as a dressing, reapply after each incidence of incontinence).  
• Use skin sealant gel on peri-ulcer skin where tape will be applied.  
• Transparent dressing for skin tears.  
• Re-consult Wound & Ostomy Team for further recommendations such as use of wound gel or if wound is draining or appears infected. | As in Skin Care Standard of Practice. (turning wedges, foam heel boots, occipital offloaders, pillows)  
Low air-loss mattress  
Total Care in ICU, or for multiple Stage II: Low air-loss mattress |
| III and IV | Consult Wound and Ostomy Team. | Normal saline and 4 x 4 with each dressing change. | • Keep wound clean, moist and protected.  
• Normal saline moist gauze BID until Wound Team consult  
• Loosely place moist gauze over all surfaces of wound bed. Do not pack. Cover with ABD and secure with Hypafix tape.  
• Use skin sealant gel on peri-ulcer skin where tape will be applied.  
• Consult Wound and Ostomy Team. | As in Skin Care Standard of Practice. (turning wedges, foam heel boots, occipital offloaders, pillows)  
Low air-loss mattress  
Total Care in ICU |
<table>
<thead>
<tr>
<th>Unstageable Dry Eschar OR Non-viable tissue slough</th>
<th>Consult Wound and Ostomy Team.</th>
<th>Do not attempt to clean.</th>
<th>Normal saline and 4 x 4 with each dressing change.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRY ESCHAR</strong></td>
<td>• Keep wound protected. Do not attempt to moisten.</td>
<td>• Apply non-adherent protective dressing such as Telfa, or Exudry.</td>
<td>• Use skin sealant gel on peri-ulcer skin where tape will be applied.</td>
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<td></td>
<td>• Secure with Kerlix, gauze or Hypa-fix tape.</td>
<td>• Consult Wound and Ostomy Team.</td>
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</tr>
<tr>
<td><strong>NONVIALBE TISSUE SLOUGH</strong></td>
<td>• NS wet-to-wet BID and prn.</td>
<td>• Cover with ABD or Exudry.</td>
<td>• Use skin sealant gel on peri-ulcer skin where tape will be applied.</td>
</tr>
<tr>
<td></td>
<td>• Secure with Kerlix, gauze or Hypa-fix tape.</td>
<td>• Consult Wound and Ostomy Team.</td>
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</tr>
<tr>
<td>SDTI Consult Wound and Ostomy Team</td>
<td>Clean gently with bath cloth, or barrier cloth.</td>
<td><strong>SUSPECTED DEEP TISSUE INJURY</strong></td>
<td>As in Skin Care Standard of Practice. (turning wedges, foam heel boots, occipital offloaders, pillows)</td>
</tr>
<tr>
<td></td>
<td>• Keep area clean, moist and protected.</td>
<td>• Moisture barrier cream to area as needed, or barrier dressing such as transparent. Avoid hydrocolloid (duoderm), as wound needs to be assessed frequently. Picture frame around hydrocolloid with Hypafix tape.</td>
<td>Low air-loss mattress, or Total Care bed in ICU</td>
</tr>
<tr>
<td></td>
<td>• Reapply barrier cream 2-3 times daily or PRN after soiling.</td>
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